North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

October 11, 2007

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-2261-P
7500 Security Boulevard, Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

Sent Via Overnight Express Mail

Dear Sir or Madam:

The North Carolina Department of Health and Human Services serves as the Single State Agency for the administration of the Medicaid Program in North Carolina. In addition, we are responsible for the delivery of services to individuals with mental illness, developmental disabilities and substance use disorders and also serve as the Single State Agency for the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant. We are also responsible for the administration of Social Services, including the administration of foster care in North Carolina. From that perspective, we believe we are uniquely qualified to comment upon the proposed rule posted for public comment by the Centers for Medicare and Medicaid Services as 42 CFR 440 and 441.

The proposed rules cause us significant concerns. They appear to reflect a belief that a person's rehabilitation from mental illness or substance use disorder follows a straight-line trajectory of continued improvement and that recovery can be achieved relatively quickly. In fact, we know that this is not the case. Individuals make progress and then experience relapse; thus, milestones along the road to recovery are sometimes measured in months or years. With some individuals, the appropriate service may be delivered for many months during which the maintenance of functioning is considered a hallmark of successful treatment. This misunderstanding of the nature of these illnesses is reflected in Section II.C. which explains the provisions of the rule. A sentence in that section states, "It is important to note that this benefit is not a custodial care benefit for individuals with chronic conditions..." In fact, mental illness and addictive diseases **are** chronic conditions; many people do achieve recovery with effective rehabilitation treatments, but they are never "cured" of the illness. We agree that Rehabilitation Option services should not be custodial; they should represent very active, clinical treatment and interventions, but the mere inclusion of this sentence seems indicative of the lack of understanding reflected throughout the proposed rules of the challenges faced by Medicaid recipients with mental illness and substance use disorders.

The President's New Freedom Commission Report, issued by this Administration, is a very forward-thinking document that provides a roadmap for how services to individuals with mental illness and substance use disorders can be improved in the United States. That report, issued just a few years ago, accurately cited the fragmented nature of the service delivery system. These proposed rules, including the assumption that these changes will reduce cost to the Medicaid Program for Rehabilitation Option services by $2.2 billion over a four year period, are moving in the opposite direction from the action agenda outlined in the New Freedom Commission Report. For these reasons, we urge CMS to withdraw these proposed rules and to engage state Medicaid and Mental Health and Substance Abuse Agencies in any future attempt at rule-making related to Rehabilitation Option services. By working through partnership, we feel we can reach an agreement to accomplish both programmatic and budgetary goals.

Our specific comments regarding individual components of the rules are as follows:

Sec. 440.130(i)(B)(v)
One of the best parts of the Notice of Proposed Rule Making is the discussion in the description of Provisions of the Proposed Rule around person-centered planning. The final two sentences of Section II. C. state "We recommend the use of a person-centered planning process. Since the rehabilitation plan identifies recovery-oriented goals, the individual must be at the center of the planning process." Despite these promising statements, it is disappointing to note that the proposed rule does not mention person-centered planning. Rather, this rule states that the rehabilitation plan is "developed by a qualified provider(s) working within the State scope of practice act, with input from the individual..." This seems to contradict the intent of the discussion and moves the approach back to a professional driven system. Without the reference in the rule, where is the authority to mandate this approach?

Sec. 440.130(d)(1)(vi)
We appreciate that the rule indicates that maintenance of a current level of functioning may be appropriate when paired with a rehabilitation goal. We have concerns about how this rule will be interpreted in individual consumers' plans. We also recommend that specific language referencing children should be added to focus on achievement of age appropriate functions rather than loss of a function the child might have had previously. These rules must be studied in relationship with EPSDT.

440.130(d)(2)
Though we recognize that Medicaid has for many years excluded payment of room and board in residential settings, it is important to note that this distinction continues the longstanding Medicaid bias toward institutional treatment settings, where room and board is recognized as a legitimate Medicaid cost, and would appear to run counter to the many initiatives that CMS has encouraged to "rebalance" the service delivery system in favor of more community-based services, including the current Money Follows the Person initiative. This incentivizes for coverage in facility based programs.

440.130(d)(3)(xiv)
We have concerns about how this section will be interpreted. In December 2005 in its approval of a State Plan Amendment for Rehabilitation Option services in NC, CMS limited the duration of services that a recipient could receive in several types of residential substance abuse services to no more than thirty (30) days in any given 12 month period. That causes us concerns that in the future that type of arbitrary timeframe may be applied to other services. Any mental health or substance abuse professional will attest that it is not reasonable to assume that consumers with severe and persistent or serious mental illness and/or substance use disorders will be able to demonstrate a "measurable reduction of disability and restoration of functional level" in a thirty (30) day period.

440.130(d)(5)
We believe that simply saying that services may be "provided in a facility, home, or other setting" provides too much room for individual interpretation by CMS Regional Offices. If CMS is going to restrict the services that can be delivered in certain settings as they have done in NC previously (see comments above for 440.130(d)(3)(xiv), those restrictions should be included in the rule.

441.45(a)(4) and (5)
We understand the critical importance of accurately documenting services delivered. However, the language in these two rules requiring inclusion of units of service could be interpreted to mean a progress note is needed for each unit of service delivered. Since many services are billed on a 15 minute unit basis, a single contact may represent four or more units of service. We hope that CMS will not increase the paperwork burden on providers by interpreting these two rules as requiring notes for each unit of service. We also believe that documentation of this nature does not drive quality care or administrative accountability. We would not begin to expect surgeons to document every 15 minutes for an activity or procedure.

We believe that these proposed rules will do significant harm to Medicaid recipients with mental illness and substance use disorders. NC has worked diligently over the past six years to improve our public system of services to these vulnerable populations. We believe that these proposed rules would cause irreparable damage to that system.

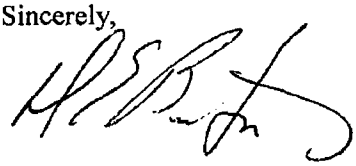
Miscellaneous Comments

It will be critical to the children of North Carolina for CMS to continue the practice of allowing habilitation and maintenance in the areas of Occupational Therapy, Physical Therapy and Speech Language Pathology. As stated in the CMS school guide "However, because occupational therapy, physical therapy and speech therapy do not have the same requirement to restore lost capabilities, habilitation services are not precluded from coverage under those service categories". Along with the school based guide, in a previous transmittal CMS recognized that the OBRA 89 legislation required maintenance to be provided to recipients under EPSDT. Clarification of the revised rehabilitation rules along with previous guidance for the specialized services will be required. Under the Individuals with Disabilities Education Act, Medicaid is the primary payer for medically necessary services provided to Medicaid students with an IEP. Congress and CMS have clearly demonstrated their intent that children be treated differently than adults when it comes to Specialized Therapies. To do any differently will have a devastating effect on a very vulnerable population.

We understand that rehabilitation services are to focus on the ability to perform a function, regardless of whether a child performed the function in the past. Although referenced for children, this is also critical for adults. As people receive services and achieve goals stated in their person centered plan, skills may be taught and achieved that the person may not have previously had due to the medical conditions. To limit a person's skill development due to such a narrow interpretation of rehabilitation would be counterproductive to a person's economic independence.

We support the use of various funding to cover the cost of care; Medicaid should not be the sole payor when other funding sources are available. However, we question the restrictiveness of the draft rules in regards to Therapeutic Foster Care. The two systems should be encouraged to work together to serve this most vulnerable population. The draft rules further fragment the systems. We encourage you to consider allowing states to establish the accountability of ensuring that funding is not mixed but does allow Medicaid to cover medical related expenses not covered by federal foster care funding. This includes specialized provider recruitment, caregiver training and other services that are part of the specialized care these children may require.

Sincerely,



Dempsey Benton

cc: N. C. Legislative Delegation
Senator Martin Nesbitt
Representative Verla Insko
William W. Lawrence, Jr., MD
Mike Moseley
Sherry Bradsher
NC Advocacy Community